

## Referral for Post Liver Transplant Follow Up

**PLEASE FILL OUT COMPLETELY** - Return to:

Medical University of South Carolina  
Liver Transplant  
160 Rutledge Avenue  
PO Box 250586  
Charleston, S.C 29425  
Phone: 843-792-0332; Fax: 843-792-3172

Date of Referral: \_\_\_\_\_ Form Complete By: \_\_\_\_\_

### PATIENT DEMOGRAPHICS

PATIENT NAME: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Ht(cm): \_\_\_\_\_ Wt(kg): \_\_\_\_\_

\_\_\_\_\_ Phone #: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Transplant: \_\_\_\_\_ Pre-Transplant Diagnosis: \_\_\_\_\_

Current Meds: \_\_\_\_\_

Allergies: \_\_\_\_\_

### PATIENT'S INSURANCE INFORMATION

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Other Insurance: \_\_\_\_\_

### REFERRING PHYSICIAN INFORMATION

Referring MD (GI): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Referring MD (Primary): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

COMPLIANCE INFORMATION

Is patient compliant with appointments/medications?  yes  no

If no, please explain: \_\_\_\_\_

How is patient paying for medications?: \_\_\_\_\_

Has patient used drugs/ETOH since time of transplant?  yes  no

If yes, please explain: \_\_\_\_\_

**Referral must include: (Please check box if attached.)**

- Completed referral form**
- Copy of all insurance cards (front & back)**
- Copy of patient's transplant flow chart (history of complications, rejection, treatment, labs)**
- Copy of transplant operative note.**
- Social Work Assessment**
- Biopsy reports**
- Imaging reports**